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VERIFICATION REQUEST

Massachusetts' Licensee: Please provide the information requested below to process your verification request. Additionally, please forward this request **along with** a check or money order for \$15.00 payable to: the Commonwealth of Massachusetts.

To Be Completed By Licensee (Please Print In Ink)

I, the undersigned Licensee, was granted a license to practice _____
(Profession)

with license number **SP-**_____ on _____ in the Commonwealth of
(License #) (Date)

Massachusetts. I request that the Board of Registration of Speech Language Pathology & Audiology forward verification of my licensure to the recipient stated below:

Name: _____

Street: _____

City: _____ State _____

Zip Code: _____

Furthermore, I hereby **authorize** the Board of Registration of Speech Language Pathology & Audiology to release my information, **favorable or otherwise**, directly to the above stated recipient.

Licensee's signature & Date _____

Licensee's printed or typed name _____

Licensee's Address: _____

Licensee's phone #: _____

